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ABSTRACT

Adolescent suicide is the second leading cause of death in the adolescent population and is on the rise. This study used a mass screening concept as a pre-test identifier of at risk clients for suicide ideation and depressions; development of a competency-based prevention group treatment program, and the post-testing of the identified at-risk population to empirically evaluate the group treatment program for its effectiveness in reducing suicidal ideation and depressive symptomatology. Subjects (N=109) were ninth grade students who completed the Suicide Ideation Questionnaire (SIQ) and the Reynold's Adolescent Depression Survey (RADS). Students who scored on or above the test manual cutoff scores were identified as "at risk-needing treatment." The identified students (N=21) were offered an 8-week group treatment program. Pre- and post-test data were analyzed for frequencies of responses on the inventories and for gender differences. Treatment (N=11) and non-treatment (N=10) group differences were analyzed. A significant difference was found between pre- and post-test RADS scores of the total population, while a trend toward significance was found in the SIQ total population sample. In spite of the small sample size, graphic representations of pre- and post-test means support the hypothesis that the treatment group would improve at a higher degree than the non-treatment group. It was concluded that the mass screening is one tool useful for early identification of at-risk youth. (Author/NB)

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ABSTRACT

MASS SCREENING: AN AID TO COMPETENCY BASED PROGRAM DEVELOPMENT
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Tomorrow in the United States approximately 1000 adolescents will attempt suicide. Eighteen will succeed (Seibel, 1988). Adolescent suicide is on the rise. It is the second leading cause of death in the adolescent population (Morrison, 1988). Barrett (1989) has written that for suicide efforts by schools to be most effective they must be part of a comprehensive program which addresses the plethora of problems faced by youth. The literature reveals numerous articles on the topic of suicide prevention in schools (AAS; 1989, Barrett; 1989, Davies, Sandoval and Wilson; 1988, et. al.), but little empirical data exists on: program out-comes, identification of at risk youth and the counseling strategies employed to intervene at a most crucial time in an adolescents life. This study involved utilizing a mass screening concept as a pre-test identifier of at risk clients for suicide ideation and depression, development of a competency based, prevention, group treatment program, and the post-testing of the identified at risk population to empirically evaluate the group treatment program for its effectiveness in reducing suicidal ideation and depressive symptomology. Subjects (N=109) were ninth grade students at a mid western high school. The instruments used in this study were the Suicide Ideation Questionnaire and the Reynold's Adolescent Depression Survey. Students who scored on or above the test manual cutoff scores (SIQ = 33, RADS = 77) were identified as "at risk-needing treatment". The identified students (N=21) were offered an eight week group treatment program. Pre and Post-test data were analyzed for frequencies of responses on the inventories and gender differences. Treatment (N=11) and non-treatment (N=10) group differences were analyzed with ANOVA analyses. A significant difference was evident between the pre and post-test RADS scores

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F(1,19, 7.09, p<.05) of the total identified population, while a trend towards significance was evident in the SIQ total population sample. Due to small sample size, statistical significance was not always evident, yet graphic representations of the pre and post-test means of the total sample and the adjusted sample support the hypothesis that the treatment group would improve at a higher degree than the non-treatment group. A significant difference was noted between the means of the students with tendencies towards suicide ideation and depression as compared to the group with no tendency toward suicide ideation or depression (SIQ & RADS, pre-ITGS =27.09 & 76.36, post-ITGS=25.27 & 68.72, pre-NTGS = 4.67 & 50.22, post-NTGS =3.67 & 48.78,). It was concluded that mass screening is one tool useful for early identification of at risk youth. The results of this study also support the use of the screening instruments to assess reduction of suicidal and depressive effects after treatment, thus, enabling counselors to empirically study the outcomes of counseling programs.

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Mass Screening An Aid To Program Development

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Adolescent suicide is on the rise. It is the second leading cause of death in the adolescent population and its incidence has doubled in the past decade (Morrison, 1988). In todays school systems every counselor must be prepared to handle the 'crys for help', that their clients scream in their direction. Not only do counselors need to be able to handle the crisis of suicide ideation, attempts and completions but they must do something to help prevent the continued increase of this tragedy. It is time for schools to take a leadership role in dealing with this tragedy that effects one adolescent every 60 seconds (U.S. Vital Statistics, 1988).

Schools across our nation are continually adding suicide prevention programs to their counseling curriculum. The prevention programs are usually a one day, mass presentation to the student population of the particular school. Most prevention programs consist of information about suicide, warning signs, myths and the steps to be taken if a student believes that he/she or one of his/her friends are suicidal. These same programs are presented, in a haphazard manner, with little or no follow up. In presenting programs to prevent suicide, counselors must take one more important step and begin to analytically study the outcomes of such prevention efforts and the impact these programs have on our youth.

It is the purpose of this research to present a new trend in the use of mass screening instruments. The use of selected mass screening instruments will enable counselors to identify

students that may truly be "at risk" and enable counselors to create counseling strategies that will service a greater number of students at the earliest possible period of their difficulties and in a shorter time frame. When students identified as "at-risk", actually are the recipients of prevention programs and interventions specifically designed to teach certain competencies or specific coping strategies, program outcomes can be tested.

Mass screening has been a technique that has been widely used in school systems across the nation in identifying readiness for kindergarten. The literature supports early -age intervention in determining the needs and suggests procedures both developmentally (Biber, 1984) and remedially (Mowbray & Salisbury, 1975). The concept used in this research is based upon the same principle; screen all of the students to determine those that are in need of special services. In keeping with recent court interpretations of PL 94-142 the stage has been set for expanding assessment to provide the best possible education, remediations and interventions to those students who appear to be unable to obtain optimum growth or development at the earliest possible time in their educational careers. The earlier we identify youngsters "at risk", the greater are our chances of helping them learn the strategies that they may need to cope with the stresses of the school, home and the community environment. Students identified can be provided special services that can be implemented into the school program at an earlier level. Mass screening at this time will aid in a creative and innovative prevention opportunity in the deterrent and prevention of adolescent suicide.

Coping strategies can be learned. As educators, we include programs in our schools that help students combat the problems of adolescence: teen pregnancy, substance abuse, divorce, etc.. If a child can learn to cope with life's problems in an effective manner, maybe we can alleviate some of the aforementioned concerns of todays youth.

Reasons For Undertaking the Project

In the past four years our school has had a suicide. Since that time, prevention programs were implemented geared towards the entire student population. Our teachers, counselors and administrators were in-serviced on the topic of suicide and its warning signs and had learned some of the basic communication skills on dealing with suicidal individuals. The concern expressed at the faculty meetings by our staff verbally and by preliminary survey from our guidance counselors, was how do we know if what a student is exhibiting is really depressive symptoms or something else? What are we doing for those students who we suspect are suicidal or depressed? What can we do as a system to best meet the needs of those students who might be depressed or suicidal that we don't know about? With these thoughts in mind we developed the following research study.

Instruments

We selected two instruments for the purpose of this research, they were the Reynold's Adolescent Depression Inventory (RADS) and the Suicide Ideation Questionnaire (SIQ). The criteria for selection included that the instruments could indicate depressive symptoms, possible suicidal ideation, be short to administer and could be hand or machine scored.

REYNOLD'S ADOLESCENT DEPRESSION INVENTORY

The RADS is a brief, easily administered, self report measure designed to assess depressive symptomology in adolescents ages 13 through 18. It is designed to be a measure for the assessment of clinically relevant levels of depressive symptomology in individual adolescents, for use as a screening measure for the identification of depression in school-based and clinical populations. The test can be administered individually or in groups.

The RADS consists of 30 items and utilizes a four point Likert -type response format. The response format requires the adolescent to select whether the symptom-related response

has occurred: almost never, hardly ever, sometimes, or most of the time. A student who scores at or above 77 on the RADS is identified for further evaluation.

SUICIDE IDEATION QUESTIONNAIRE

The Suicide Ideation Questionnaire was designed to assess one aspect of suicidal behavior-suicidal ideation. The test can be administered individually or in groups. The SIQ, comes in two forms, a high school form (grades 10-12) and a junior high school form (grades 7-9). The SIQ-JR was used in this study and is a 15 item test. The respondent rates the SIQ items on a 7-point Likert type scale which assesses the frequency with which the suicidal cognition occurs. The items are scored from 6 to 0. An adolescent who scores at or above 31 on the SIQ-JR should be referred for further evaluation of potentially significant suicidal risk.

A number of items on the SIQ have been identified as critical items on the basis of their potency for more serious self destructive behavior. The critical items are those which deal specifically with actual suicidal thoughts and plans for the suicide.

SAMPLE AND PROCEDURES

One hundred and nine high school freshmen at a mid western high school were screened for the purpose of this study. The sample was composed of 60 males and 49 females. The administration of the SIQ and the RADS was completed in January of 1990, through an English class, a required course for all freshmen. By adhering to the set identification score points for the individual test instruments (SIQ = 31, RADS = 77), as determined in the test manuals, twenty-one students (19% of the sample) were identified as "at risk-needing treatment".

The students who were identified as "at risk-needing treatment" were offered membership in an eight week group guidance program. The program was voluntary. Parents were also contacted by letter that their child had been offered membership in the group program. Students were required to have parent permission to enter the group. If the student

had been recommended for the group, but chose not to participate in the program, a parent signature was also required. This signature was acknowledgment that the parent had been informed that group treatment had been offered and was allowing the student to refuse group participation. Eleven students (11) selected to participate in the group counseling program, the remaining ten students (10) chose not to participate in the offered treatment group and therefore were deemed the control group for this study. One week after identification the group began. At the conclusion of the eight week group treatment program the twenty-one students were post tested.

THE GROUP

A thorough review of the literature regarding suicide prevention programs (ERIC and Psych. Abstracts, 1980-1990) revealed certain commonalties. The commonalties relevant to the literature review related to suicide, as well as, to improving coping strategies for problem solving and stress reduction and self esteem. The group sessions were developed with these ideas in mind and are described briefly below. Attention is given to the issues as well as the strategies used.

Session One: Building Self Esteem

Group members discussed their reactions to open-ended questions that were presented as a method of getting to know themselves and other group members better. The remainder of the session was devoted to expressing goals that each member wished to attain from being a part of the group.

Session Two: Controlling Anger

Participants discussed and identified the antecedents, anger "clues", and anger responses to situations they had experienced. Group members were then taught to recognize and change irrational thoughts eliciting anger responses and new behaviors were practiced

through role plays.

Session Three: Assertiveness

The participants recognized assertive, passive and aggressive styles of behavior. Role-play situations enabled the group members to practice assertive behaviors.

Session Four: Refusal Skill Training

Participants were taught a five step model for refusing others in a manner that allowed them to feel good about themselves while not alienating their friends. Coping skills were practiced through role-play situations utilizing the five-step model. The remaining portion of the group was spent on other coping strategies.

Session Five: Crisis Intervention

Participants watched a video "You're Only Human", by Billy Joel. Students then commented on what they saw and how it was similar to the ways that they had felt in their lifetime. Time permitting students viewed selected segments of "Dead Poet's Society", with discussion centered on the recognition of the warning signs of adolescent suicide. The participants were given several hypothetical situations and were asked to identify the symptoms and responses to the situations. This topic was often carried in to session six.

Session six: Decision Making

The students were given multiple problem situations and asked to respond to how they would solve the problem. A decision making model was then presented and the members were asked to solve the problems again, this time, based on the model.

Session Seven: Relaxation and Stress Reduction

A nurse from a local hospital instructed the students in various methods of relaxation including muscle relaxation, systematic desensitization, and thought-stopping. Students practiced these techniques as a relaxation tape was played. Each student was given a home work

assignment to bring a tape that they could use to help them relax to the next session.

Session Eight: Closing and Posttestting

The members completed a post test copy of the RADS and the SIQ. The members discussed and evaluated the goals that were set at the beginning of the group sessions. In addition, each member offered positive feedback to each member in the group. The culminating activity was a pizza and pop party. Students were then scheduled to have an individual counseling session with the counselor to discuss strengths learned in the group and areas that the client needed to work on. Depending on the scores on the students post test on the administered instruments a plan for further counseling was discussed with the individual. Parent contact might also be necessitated at this time.

RESULTS

The treatment group for the purpose of this study was created by identifying those students who scored at or above the cutoff score points as determined by the specific testing manual (SIQ=33, RADS=77). The raw scores for the SIQ and the RADS for the identified population are listed in Table 1. In the pre-test administration of the instruments 19% were identified by the SIQ, 48% were identified by the RADS and 29% were identified by both instruments. The treatment group had 18% of the students identified by the SIQ, 46% by the RADS and 27% by both, as compared to the non-treatment group which had 20% by the SIQ, 30% by the RADS and 50% by both instruments. Eleven males and ten females were identified through the screening procedure. The treatment and non-treatment groups had equal numbers of males and females in their composition.

Table 2 represents the pre and post-test SIQ means of the total sample and adjusted sample for the treatment (TSG1, Adj.SG1) and the non-treatment groups (TSG2, Adj. SG2). It appeared that in the total sample data that although no significant difference was observed in the

ANOVA analysis a trend toward significance was noted. In a graphic representation of the pre and post test SIQ means for the total sample, both groups appeared to improve on the SIQ (TSG1, pre = 27.09, post = 25.27, TSG2, pre =28.40, post =18.60), with the non-treatment group appearing to improve to a greater degree (see diagram 1). Since it was hypothesized that the treatment group would show a significant difference over the non-treatment group the results of the non-treatment group required further investigation. Upon investigation it was found that five members of the non-treatment group received various forms of counseling during the time of this study. The data from the five non-treatment individuals were deleted from the analyses and the data reanalyzed. Due to small sample size true statistical significance was not always evident, yet graphic representation of the pre and post-test SIQ adjusted sample data (Adj. SG1, pre= 29.20, post = 26.60, Adj.SG2, pre = 20.00, post = 20.60) appear to support the hypothesis that the treatment group would improve at a higher degree than the non-treatment group (see diagram 2). The results will be represented with the inclusion of the total sample results and the adjusted sample results for the remainder of this paper.

Table 3 represents the total sample and adjusted sample pre and post-test means for the RADS for the treatment and non-treatment group. Significance was noted in the pre and post test results of the total sample, while, a trend towards significance was noted in the adjusted sample. Graphic representations of the total sample and the adjusted sample, again, seem to support the hypothesis (see diagram 3 and 4).

Table 4 and Table 5 represent the total sample and the adjusted sample pre and post-test means, respectively, on the SIQ critical items for both groups. A trend towards significance is noted in statement #7, 'I thought about what to write in a suicide note', while the remaining statements did not reveal any statistical significance in the total sample. The adjusted sample revealed no significant differences on any of the SIQ critical items.

Table 6 and Table 7 represent the total sample and the adjusted sample pre and post-test means, respectively, on the RADS critical items for both groups. Significance is noted on statement #20 and #30, $F(1,19) = 11.75$ and 7.54, $p<.05$), 'I feel I am no good' and 'I feel like nothing I do helps any more' with a trend towards significance on statement #14, 'I feel like hurting myself', in the total sample. The adjusted sample revealed significance on statement #20, $F(1,19) = 5.70$, $p< .05$), 'I feel I am no good' and a trend toward significance on the statement #30, 'I feel like nothing I do helps any more'.

The findings of the current study add some information to our knowledge regarding research and treatment of "at risk" populations. First, because the study involved clients with a trend towards suicide ideation and depression, "delayed treatment" strategies could not be employed. Further research of this type might want to include multiple treatment approaches and also allow for client selection of treatment rather than a forced choice treatment. Fifty per cent (50%) of the identified population chose not to be part of the group treatment program, yet fifty per cent (50%) of the control sample sought some form of counseling treatment during the time of this study. It is possible that students chose not to participate in this group because of scheduling difficulties but it would also appear that if an alternate treatment would have been available a larger sample may have been involved in this program.

Using the total sample to discuss the changes between the two groups also follows with the literature on crisis situations, in as much as, people will resolve their crisis issues with or without help in a specified period of time. Studies of coping skills, strategies and coping levels should be considered after the treatment. Although both groups seemed to improve, it is difficult to know what coping functioning level individuals have attained when no treatment is administered.

Schools specifically school counselors, frequently are required to provide suicide

prevention programs as part of their curriculum. As stated by Barrett (1989), suicide prevention efforts by schools are most effective when they are part of a comprehensive program which addresses the plethora of problems faced by youth. With the results of this study in mind counselors should: 1. implement prevention programs that are longer than one day, facts and information programs, 2. use multiple methods to assess for those students who might be at risk, 3. develop treatment programs that include multiple treatment choices to meet the clients needs, 4. undertake outcome studies to analyze the effects of programs and the impacts of the programs on the clients that we serve, and finally, 5. implement treatment programs for suicide that include strategies to increase the stress and problem solving coping strategies of students involved at the earliest possible time in their development.

These suggestions will lead towards the development of comprehensive, competency-based prevention programs. Mass Screening is, therefore, one method counselors can use to begin to identify "at risk" populations and to begin to create and build competency based counseling programs.

REFERENCES

Barrett, Thomas, C., Teens in Crisis: Preventing Suicide and Other Self-Destructive Behavior", American Association of School Administratrators, Arlington, Virginia, 1989.

Davies, B.J., Sandoval, J., and Wilson, M. "Strategies for the Primary Prevention of Adolescent Suicide", School Psychology Review, 1988.

Morrison, James L., "Youth Suicide An Intervention Strategy", Social Work, Nov.-Dec. 1987.

PAR, Suicide Ideation Questionnaire Test Manual, PAR, 1989.

PAR, The Reynold's Adolescent Survey Test Manual, PAR, 1989.

U.S. Vital Statistics Report, Washington, D.C., 1988.

Walsh, Herman, "Kindergarten Screening The Counselors Role", Elementary Guidance and Counseling Journal, January, 1990.

TABLE 1

Pre and Post-test SIQ and RADS Test Scores of the Identified "At Risk Needing Treatment" Clients

SUBJECT	PRE	POST	PRE	POST	PRE	POST
TGS1	10	6	77	38	*R	
TGS2	60	57	94	93	**SR	**SR
TGS3	17	17	78	65	*R	
TGS4	17	28	78	78	*R	*R
TGS5	17	61	86	94	**SR	**SR
TGS6	31	18	62	56	*S	
TGS7	41	39	81	87	**SR	**SR
TGS8	8	7	77	70	*R	
TGS9	6	12	77	57	*R	
TGS10	31	14	69	57	*S	
TGS11	30	12	81	76	*R	
NGS12	10	8	82	76	*R	
NGS13	16	18	77	75	*R	
NGS14	19	19	77	60	**SR	
NGS15	33	6	81	52	**SR	
NGS16	34	9	81	40	**SR	
NGS17	28	17	80	81	*R	*R
NGS18	32	30	77	76	*SR	
NGS19	10	12	81	72	*R	
NGS20	33	30	62	64	*S	
NGS21	57	17	65	60	*S	

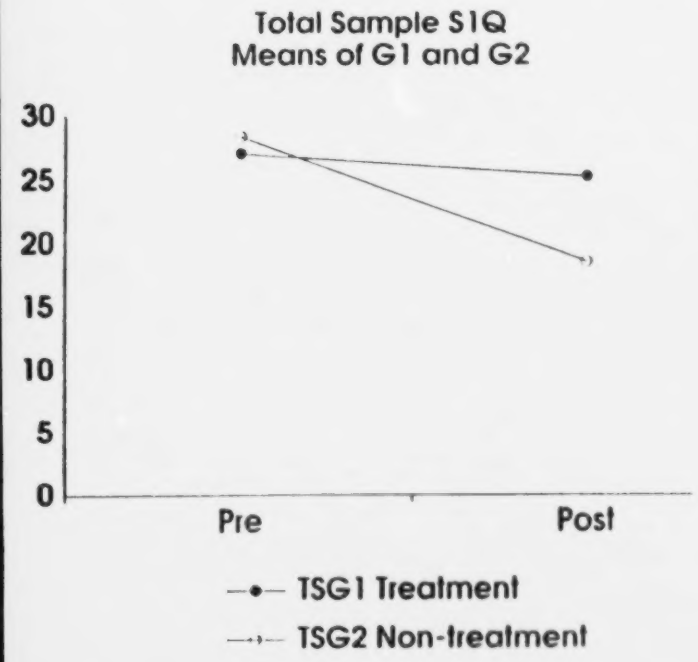
CUTOFF SCORE (SIQ=31, RADS=77)
TGS# = Treatment Group Subject Number
NGS# = Non-treatment Group Subject Number
*S = Identified by the SIQ Alone
*R = Identified by the RADS alone
**SR = Identified by the SIQ and the RADS

TABLE 2

Pre and Post-test SIQ Mean Scores of the Total and Adjusted Sample

GROUP	PRE SIQ	POST SIQ	F	p
Total Sample Group 1	27.091	25.173		
			4.22	.0540[a]
Total Sample Group 2	28.400	18.600		
Adj. Sample Group 1	29.20	26.60		
			.21	.6516
Adj. Sample Group 2	20.00	20.60		

*p<.05 a = trends toward significance



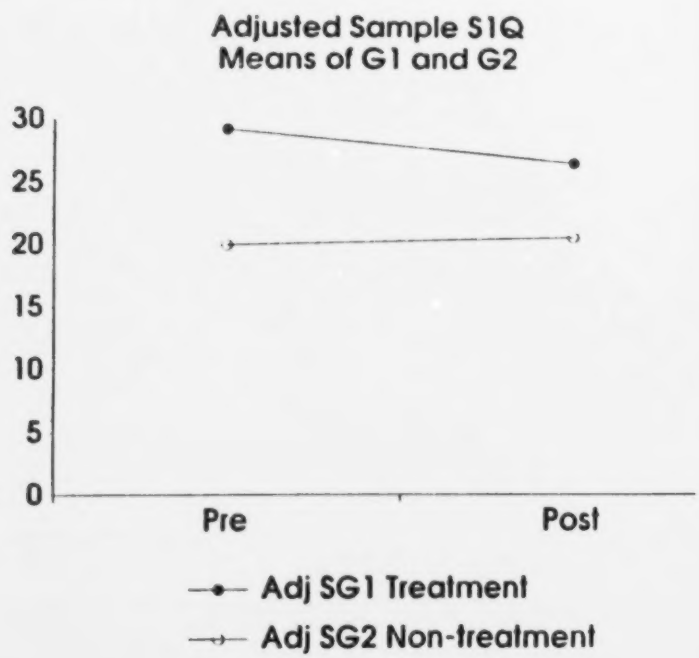
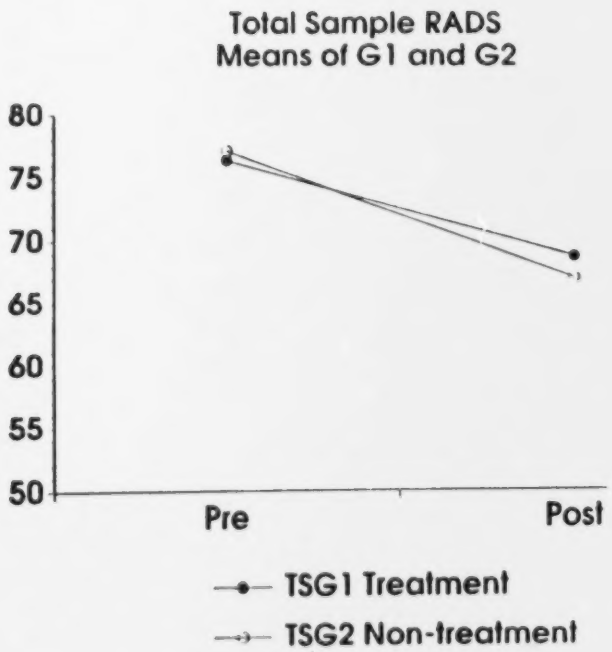


TABLE 3

Pre and Post-test RADS Mean Scores of the Total and Adjusted Sample

GROUP	PRE RADS	POST RADS	F	p
Total Sample Group 1	76.36	68.72		
			7.09	.0154 **
Total Sample Group 2	77.10	67.00		
Adj. Sample Group 1	78.00	69.70		
			3.32	.091[a]
Adj. Sample Group 2	75.80	72.80		

*p<.05 a= trend toward significance



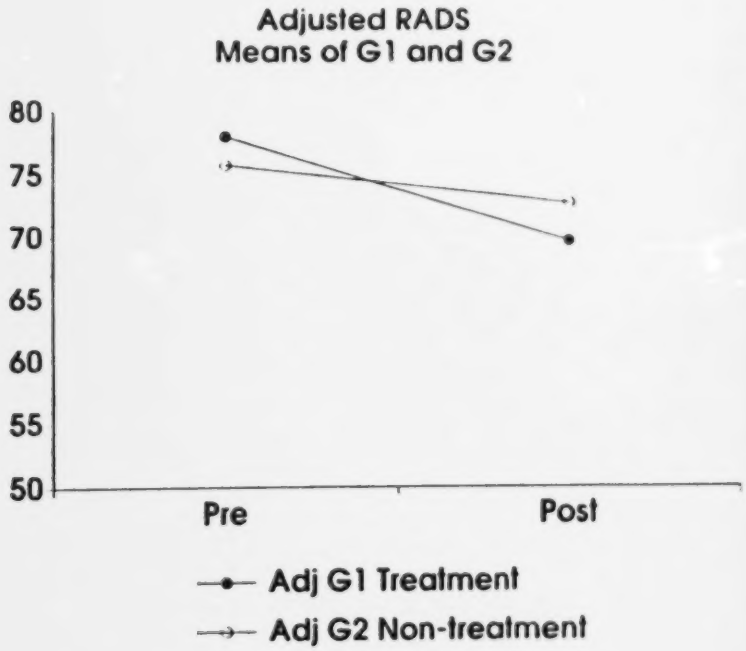


TABLE 4

Pre and Post-test SIQ Critical Item Mean Scores of the Total Sample

ITEM	GROUP 1		GROUP 2		F	p
	PRE	POST	PRE	POST		
3. I thought about killing myself	1.45	1.36	1.50	1.10	1.03	.3231
4. I thought about how I would kill myself	1.00	1.00	1.70	1.30	.52	.4780
5. I thought about when I would kill myself	.36	1.09	1.60	.80	.01	.9157
7. I thought about what to write in a suicide note	.45	1.00	.40	.80	3.54	.0753a
8. I thought about writing a will	.363	.454	.40	.50	.46	.5038
9. I thought about telling people I plan to kill myself	.363	.273	.40	.50	.00	.9704

Pre and Post-test SIQ Critical Item Mean Scores of the Total Sample

ITEM	GROUP 1		GROUP 2		F	p
	PRE	POST	PRE	POST		
3. I thought about killing myself	1.45	1.36	1.50	1.10	1.03	.3231
4. I thought about how I would kill myself	1.00	1.00	1.70	1.30	.52	.4780
5. I thought about when I would kill myself	.36	1.09	1.60	.80	.01	.9157
7. I thought about what to write in a suicide note	.45	1.00	.40	.80	3.54	.0753a
8. I thought about writing a will	.363	.454	.40	.50	.46	.5038
9. I thought about telling people I plan to kill myself	.363	.273	.40	.50	.00	.9704

*p<.05 a= trend towards significance

TABLE 6

Pre and Post-test RADS Critical Item Mean Scores of the Total Sample

ITEM	GROUP 1		GROUP 2		F	p
	PRE	POST	PRE	POST		
6. I feel like hiding from people	2.81	2.27	2.50	2.50	1.11	.3057
14.I feel like hurting myself	2.45	2.09	2.40	2.10	4.12	.0567a
20.I feel I am no good	2.72	2.30	2.09	1.70	11.7	.0028**
26.I feel worried	2.63	2.81	3.20	2.80	.24	.6323
29.I like eating meals	2.00	1.90	2.10	2.00	.18	.6735
30.I feel like nothing I do helps any more	2.90	2.27	3.00	2.50	7.54	.0129*

*p<.05, **p< .01 a= trend towards significance

TABLE 7

Pre and Post-test RADS Critical Item Mean Scores of the Adjusted Sample

ITEM	GROUP 1		GROUP 2		F	p
	PRE	POST	PRE	POST		
6. I feel like hiding from people	2.90	2.30	2.60	2.80	.33	.5772
14. I feel like hurting myself	2.60	2.20	2.60	2.60	1.58	.2315
20. I feel I am no good	2.80	2.20	2.20	1.80	5.70	.0328*
26. I feel worried	2.70	2.80	3.40	2.80	.77	.3966
29. I like eating meals	2.10	2.00	2.20	2.40	.04	.8359
30. I feel like nothing I do helps any more	3.00	2.40	3.20	2.80	3.74	.0753a

*p<.05 a= trend towards significance